Wyoming Peer Specialist
Certification Application

☐ Provisional ☐ Initial ☐ Recertification ☐ Mastery Endorsement

Experience Area: ☐ Mental Health ☐ Substance Abuse Addiction ☐ Dual Diagnoses

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General Information

Today's Date

Peer Specialist Candidate:

Name

Mailing Address

Town State WY Zip

Phone Number

Email

Date when you first were hired as a peer specialist:

Name of Community Center Where Employed:

Center Director's Name:
Letter of recommendation attached? __ yes __ no

Name of person who directly supervises the Peer Specialist:
Licensing credentials (i.e. LCSW, LPC):

Date when Wellness Recovery Action Plan (Wrap®) or equivalent was completed:
(Attach copy of WRAP certificate or include completion information in Director's letter.)

Date when local center orientation was completed:

If applying for Initial Certification, date when provisional certification was granted:
If applying for Recertification, date when last certification was granted:

FOR INITIAL CERTIFICATION ONLY

- Date when Peer Specialist Introductory Training was completed:
  Name of Training:

  City where it was held:

Please attach certificate or letter showing completion of initial training.

Notes:

FOR INITIAL AND RECERTIFICATION

- Date when MHSASD Peer Specialist Annual Training was last attended:

- Date when other statewide or regional training was attended:

  Name of Training:
  Town where it was held:
  Please attach certificate showing completion of training and the agenda

- Local Training (3 required during previous 12 months)

	Dates	Topic(s)
1		
2		
3		

Please attach up to two pages of documentation for each local training.

FOR RECERTIFICATION

Average number of hours I worked per month during the past 12 months:

FOR MASTERY ENDORESEMENT

A Mastery Endorsement ay be applied for annually in addition to the other certification. Two criteria are required for the endorsement. Please see the certification requirements for a list of possible Mastery Endorsement criteria.

	Dates	Criteria Completed (summary)	Location
1	-		
2	-		

Please attach up to three (3) pages of information documenting mastery activities. i.e. newspaper clippings, certificate of attendance, documentation letter, etc.

*** Please provide the following information to assist with improvement and maintenance of the Peer Specialist program.

1. What I like best about my peer specialist position:

2. What I like least about my peer specialist position:

3. Training that I could use during the next year:

4. One thing that the Mental Health & Substance Abuse Division could do differently to help the Peer Specialist program:

By signing below I certify that I am currently employed as a Peer Specialist at a Wyoming Mental Health and/or Substance Abuse Center and assigned work appropriate to my experience and background; I have been or am a consumer of mental health or dual diagnoses or substance abuse addiction services, and I am well rounded in my recovery; I hold a high school diploma or equivalent; I am at least 21 years of age or older; and that all of the information is true and complete.

If this is a Provisional Application, I agree to complete a Wellness Recovery Action Plan within sixty days and I agree to complete the Initial Certification criteria within nine months of today's date.

I understand that this certification allows the Community Mental Health/Substance Abuse Treatment Center to bill Wyoming Medicaid (EqualityCare) for Peer Specialist Services that are provided by me to clients with Medicaid coverage when these services are identified within the client's treatment plan.

_____	_____	_____
Name (printed)	Signature	Today's Date

Center Director Endorsement

By signing below I recommend this candidate for Peer Specialist Certification; that the Center has established criteria to hire, train, and retain the Peer Specialist and that this information is utilized within the candidate's employment; that the Center shall utilize grant or other funds to pay for the Candidate's certification and training needs; that a supervisor provides support for the Peer Specialist; and that the Center maintains the integrity of the Peer Specialist role as a fully integrated team member who provides highly individualized services in the community and promotes client self-determination and decision-making.

I understand that this certification allows the Community Mental Health/Substance Abuse Treatment Center to bill Wyoming Medicaid (EqualityCare) for Peer Specialist Services that are provided by this Peer Specialist to clients with Medicaid coverage when these services are identified within the client's treatment plan.

_____	_____	_____
Name (printed)	Signature	Today's Date

Internal MHSASD Use Only

Date received _____ Notes:
Date letter of findings or certificate mailed _____
☐ Approved ☐ Not-approved
Processed by: _____